TennCare Operational Protocol

Chapter 5: Quality of Care

Section 5.1
Evaluation Design

5.1.1 Program Objectives

The purpose of the TennCare Demonstration is to demonstrate that a Medicaid managed care program can be organized to save the state enough dollars to be able to expand coverage to people who are not Medicaid-eligible, while at the same time ensuring access to quality care for all enrollees.

Part II of the Special Terms and Conditions (STCs) lists six objectives for the TennCare program. The design of the evaluation is intended to focus on these six objectives. They are as follows:

- Use a managed care approach to provide services to Medicaid state plan and Demonstration eligibles at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program
- Assure appropriate access to care for enrollees
- Provide quality of care to enrollees
- Assure enrollees' satisfaction with services
- Improve health care for program enrollees
- Assure that participating health plans maintain stability and viability while meeting all contract and program requirements

5.1.2 Summary of Evaluation Plan

STC #65 required TennCare to file a draft Evaluation plan by 120 days following CMS's approval of the Demonstration extension. This draft Evaluation was approved by CMS on March 31, 2008. TennCare's evaluation plan focuses on each of the above elements. Measures to assess these elements, together with the frequency of use, are shown in Table 5-1 below.

HEDIS and CAHPS data are used in assessing progress on several of the measures. HEDIS is short for Healthcare Effectiveness Data and Information Set, which is a tool, used by more than 90 percent of America's health plans to measure performance on important domains of care and service. HEDIS employs standardized methodologies to ensure the integrity of reporting.

CAHPS is the term used for Consumer Assessment of Healthcare Providers and Systems. It is a survey tool used widely for measuring consumer satisfaction with the quality of care and customer service provided by health plans.

Table 5-1
Overall TennCare Evaluation Measures

The Performance Measures listed in this table come from the Evaluation Plan (EP), pages 13 through 25, submitted to CMS and approved by CMS on March 31, 2008.

Domain	Performance Measures	Frequency of Measurement
Spending on TennCare versus spending on Medicaid [EP Objective 1, page 13]	Maintenance of budget neutrality	Quarterly and Annual Reports required by STCs #44 and #45 [EP 1]
Access to care for enrollees [EP Objective 2, pages 14 - 15]	Increases in the statewide weighted HEDIS scores for adult access to preventive/ambulatory health services Increases in the statewide weighted HEDIS scores for children and adolescents' access to primary care practitioners Responses to annual beneficiary satisfaction survey, regarding where enrollees report that they go for care when they are initially seeking health care	Annually [EP 2.1] Annually [EP 2.2] Annually, in September of each year (per STC #46) [EP 2.3]
Quality of care [EP Objective 3, pages 16 - 18]	Increases in the statewide weighted HEDIS average for adolescent well-care visits Increases in the statewide weighted HEDIS timeliness of accessing prenatal care measure Increases in the statewide weighted HEDIS rate for breast cancer screening Increases in the statewide weighted HEDIS rate for cervical cancer screening Improvements in documentation of the required seven components of an EPSDT screen	Annually [EP 3.1] Annually [EP 3.2] Annually [EP 3.3] Annually [EP 3.4] Annually [EP 3.5]
Enrollee satisfaction [EP Objective 4, pages 19 - 20]	Increases in satisfaction as reported in the annual beneficiary satisfaction survey. Increases in the statewide weighted CAHPS measure of the percent of adults reporting that they always or usually get needed care Increases in the statewide weighted Child	Annually, in September of each year (per STC# 46) [EP 4.1] Annually [EP 4.2]

Domain	Performance Measures	Frequency of Measurement
	CAHPS measure of the percent of children who always or usually get care	Annually [EP 4.3]
Health status indicators [EP Objective 5, pages 21 - 23]	Increases in the statewide HEDIS rate HbA1c testing in patients with diabetes	Annually [EP 5.1]
	Increases in the statewide HEDIS measure for good control of HbA1c	Annually [EP 5.2]
	Increases in the statewide weighted HEDIS measure for controlling high blood pressure	Annually [EP 5.3]
	Increases in the statewide rate at which members hospitalized for mental illness remain in the community within 30 days of discharge from a psychiatric hospital	Annually [EP 5.4]
	Achievement of total statewide EPSDT screening ratio of at least 80 percent	Annually [EP 5.5]
Stability and viability of health care plans [EP Objective 6, pages 24 - 25]	Improvements in percent of TennCare MCCs that will have demonstrated compliance with statutory claims processing standards in at least 10 out of 12 months in a calendar year	Quarterly or monthly [EP 6.1]
	For those MCOs that had a minimum of two eligible requests for independent reviews submitted by providers in a calendar year, increases in the percentage of reviews determined by the independent reviewers to be favorable to the MCC	Annually [EP 6.2]

Reports on the findings associated with these measurements are summarized in the quarterly and annual reports that TennCare files with CMS, pursuant to STCs #44 and #45.

Section 5.2
Quality Assurance

5.2.1 MCO Quality Monitoring

The Division of Quality Oversight is responsible for monitoring and ensuring that TennCare members have access to timely, appropriate, high quality, medically necessary, covered healthcare services and experience quality health outcomes. Monitoring activities are either provided directly by Quality Oversight or in concert with TennCare contractors.

TennCare has mandated that all Managed Care Organizations (MCOs) participating in the TennCare Project be accredited by the National Committee for Quality Assurance (NCQA). [Tennessee was the first state to require all of their MCOs to be NCQA-accredited.] MCOs that were already participating in TennCare prior to 2007 met the requirement of NCQA accreditation. New MCOs must be NCQA-accredited by the specified time frame in each MCO's contract. The MCOs selected for the Middle Grand Division, AmeriChoice and AmeriGroup Community Care, have already met NCQA accreditation requirements. NCQA accreditation was selected because the accreditation survey process encompasses a comprehensive review of the key aspects of care and service and the overall quality of care provided by individual MCOs. The contracts of Managed Care Organizations failing to obtain NCQA accreditation will be terminated by the Bureau of TennCare, leaving only those MCOs providing the highest quality of care and service to serve the TennCare population.

As part of the accreditation process, the MCOs perform the Medicaid version of the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Study (CAHPS Survey). HEDIS and CAHPS will allow a reliable comparison of the performance of TennCare MCOs to other Medicaid managed care health plans.

HEDIS data is audited by a NCQA-certified HEDIS auditor prior to submission to TennCare and NCQA. Analysis of data allows TennCare to assess MCO specific performances and perform comparative analyses of TennCare to other Medicaid managed care plans throughout the country. This data will be used to identify best practices and determine opportunities for improvement among the TennCare MCOs.

The CAHPS survey tool measures health care consumers' satisfaction with the quality of care and customer service provided by their health plans. Audited HEDIS and CAHPS data is required to be submitted to TennCare annually for review and analysis. MCOs are required to report NCQA Accreditation findings, level of accreditation awarded by NCQA and any changes in accreditation status to TennCare.

5.2.2 Network Access

MCCs must assure that there are an adequate number of primary care providers, specialists and other service providers who are willing and able to provide the level of care and range of services necessary to meet the needs of the members enrolled in their Plan. The MCCs, according to each MCO's contract, must demonstrate their ability to provide all contracted services on a timely basis and assure accessibility to services. The Provider Networks Unit evaluates MCC provider networks on a routine basis and, where non-compliance is indicated, a corrective action plan is requested.

5.2.3 External Quality Review Organization (EQRO) Activities

TennCare contracts with an EQRO to support independent, external reviews of the quality of services available to enrollees in the TennCare project. The EQRO assists the

Bureau of TennCare in reaching its goal of ensuring that each enrollee can access timely, high quality, medically necessary, covered healthcare services.

The EQRO provides services that are consistent with the following:

- Applicable Federal External Quality Review (EQR) regulations and protocols for Medicaid Managed Care Organizations,
- State-specific requirements related to Federal court orders, including *Grier*, *John B,* and *Newberry*; and
- Contractor Risk Agreements (CRA) with TennCare Managed Care Contractors including the Managed Care Organizations, Behavioral Health Organizations, and the Dental Benefits Manager.

Reference: See STC #65.

5.2.4 EPSDT Focused Efforts

The state is taking a number of steps to improve the provision of EPSDT screenings and services. In accordance with their contract, MCOs participating in TennCare must conduct effective outreach and education programs; provide transportation and scheduling assistance for each eligible child's periodic examination; and conduct extensive provider education.

EPSDT screens are to be provided in accordance with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care" periodicity schedule. Annually, the Division of Quality Oversight monitors the MCOs' performance with respect to the provision of EPSDT screens and a statistically valid sample of medical records is reviewed to measure whether the seven required components of the screen have been performed. MCOs are required to submit corrective action plans to address deficiencies found in any of the required screening components.

Specific performance targets have been established for EPSDT screens and incentives have been included in the CRA to encourage and maintain compliance with the performance targets.

Reference: American Academy of Pediatrics Recommendations for EPSDT Screens
http://pediatrics.aappublications.org/cgi/content/full/105/3/645

Section 5.3
Grievance and Appeal Policies

5.3.1 Eligibility Appeals

TennCare enrollees may appeal actions affecting their TennCare eligibility. "Action" is defined as a termination, suspension or reduction of Medicaid eligibility. Individuals applying for TennCare may appeal denials of their application for TennCare.

The Bureau of TennCare has delegated to DHS the authority to make eligibility-related determinations, including taking final administrative action in the context of eligibility-related appeals. The Division of Appeals and Hearings within DHS has the responsibility, utilizing a single administrative process, for both TennCare Medicaid and TennCare Standard eligibility-related appeals. TennCare, as the administrative unit within the Single State Agency, retains the authority for final decision-making on appeals.

Based on approved processes and in accordance with applicable federal requirements, TennCare has implemented the following structure for eligibility-related appeals:

- When an enrollee's eligibility for TennCare is terminated, suspended or reduced, individuals are provided at least 20-days advance notice. This notice informs the enrollee of (i) the reason for the action, (ii) the legal basis for the proposed action, (iii) the right to request a fair hearing, and (iv) the right to request continuation of benefits. Enrollees are provided 40 days from the date of the notice to request a fair hearing. Enrollees who request a fair hearing prior to the date of action will retain their TennCare benefits pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.

- When an individual's application for TennCare is denied, individuals are provided notice. This notice informs enrollee of (i) the reason for the denial, (ii) the legal basis for the denial, and (iii) the right to request a fair hearing. Individuals are provided 40 days from the date of the notice to request a fair hearing.

- Requests for fair hearings are only granted for those individuals who have raised a valid factual dispute related to the action taken by the state. DHS is responsible for reviewing each request for a hearing to determine if it is based on a valid factual dispute. If DHS determines that there is no indication of a valid factual dispute, DHS will send the individual a letter asking him to submit additional clarification of any issue of factual dispute on which the appeal is based within 10 days. Unless such clarification is timely received and is determined by DHS to establish a valid factual dispute, DHS will dismiss the request for a fair hearing. If DHS determines that the individual has requested a hearing based on a valid factual dispute, the case proceeds to a fair hearing.

- When an appeal is scheduled for a hearing, DHS provides the enrollee a written Notice of Hearing. The Notice of Hearing identifies the time and location of the hearing, informs the enrollee of his right to be represented by counsel; cites the legal authority under which the hearing will be held; and provides a brief statement of the position asserted by DHS. Enrollees may represent themselves at the hearing or may retain someone to represent them at the hearing. Free or low-cost representation is often available from the local Legal Services Office. DHS provides the enrollee with a list of all Legal Services offices throughout the State of Tennessee.

Reference: See Rules 1200-13-13-.02(7) and 1200-13-14-.02(7).

5.3.2 Service and Benefit Appeals

TennCare enrollees have the right to appeal adverse actions affecting their TennCare benefits. Adverse actions include but are not limited to, delays, denials, reductions, suspensions or terminations of TennCare benefits as well as any other act or omission of the TennCare program which impairs the quality, timeliness or availability of such benefits. The Bureau of TennCare is responsible for processing service-related appeals.

The state will continue to follow these procedures throughout the Demonstration approval period unless modified through an approved Demonstration amendment.

Notice and appeal processes include but are not limited to:

- When an adverse action is taken affecting TennCare benefits by the state, managed care entities or providers, enrollees are provided with a notice of appeal rights. The timing of the notice depends on the nature of the adverse action. For example, notice is provided to enrollees upon denials of payment for claims for services that have exceeded applicable benefit limits.

- The notice of appeal informs enrollees of (i) the type and amount of services at issue, (ii) a statement of reasons for the proposed action, (iii) the legal basis for the proposed adverse action, (iv) the right to request a fair hearing, including the right to request an expedited appeal and (v) if applicable, the right to continuation of services pending appeal. Enrollees have 30 days from the date of the notice to request a fair hearing. In circumstances when enrollees have a right to request continuation of benefits, benefits will be continued if the enrollee requests a fair hearing prior to the date of the adverse action.

- Requests for fair hearings are only granted for those individuals who have raised a valid factual dispute related to the adverse action. The TennCare Solutions Unit (TSU) will review each request for a hearing to determine if it is based on a valid factual dispute. If the enrollee fails to establish a valid factual dispute, TSU will dismiss the request for a fair hearing. If TSU determines that the individual has requested a hearing based on a valid factual dispute, the case proceeds to a fair hearing.

- When a medical service appeal is scheduled for a hearing, TennCare's Legal Solutions Unit (LSU) of the Member Services Division provides the enrollee a written Notice of Hearing. The Notice of Hearing identifies the time and location of the hearing; informs the enrollee of his right to be represented by counsel; cites the legal authority under which the hearing will be held; and provides a brief statement of the position asserted by TennCare. Enrollees may represent themselves at the hearing or may retain someone to represent them at the hearing. Free or low-cost representation is often available from the local Legal Services Office. TennCare provides the enrollee with a list of all Legal Services offices throughout the State of Tennessee.

Reference: See Rules 1200-13-13-.11 & 1200-13-14-02.11.